



Health Policy Briefing Regarding Work in Progress (Revised)

A Discussion of Health Policy Issues to be Addressed in the Maryland Health Care Commission's Report to the General Assembly

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Outline

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 - Cost, quality, access and the uninsured, information
- Quality, Outcomes, and Value Initiatives
- Initiatives to promote higher value in health care expenditures
- Health Information Technology Initiatives
- Specific Small Group Market Options
 - NAIC 1993 rating standards
 - Strategies to address risk selection from ERISA plans or uninsured
 - Subsidized reinsurance for the SGM
 - Expansion to 75 or 100 employee groups
 - Internet-based intermediary proposal
- Broader health reform principles and options
 - Massachusetts reforms
 - Senator Pipkin's proposal (CHOICE)
 - Maryland Health (staff option)

I.

Overview of the Issues

Fundamental Issues

- **Health care costs** are much higher than in other developed countries and continue to rise more rapidly than income or GDP
 - **Technology is a key driver.** New drugs, diagnostic tools, procedures are introduced early and used extensively
 - **Lack of information** about effectiveness, best practices, relative value
 - **Misaligned incentives** of third-party payments provide little reason for patients and providers to pay attention to cost and value
 - **Spectre of liability** leads to defensive medicine
- **Health care quality** is quite variable
 - Wide variations in practice patterns, adherence to guidelines
 - Unacceptably high rate of medical errors
 - Care of chronic illness is poorly coordinated
 - Management tools (information systems and incentives) are weak
 - Current incentives do little to encourage quality care

Fundamental Issues (cont.)

■ Health care markets are flawed

- Incentives are misaligned
 - Payment for services rather than payment for outcomes
 - Third party payments mean neither doctor nor patient has a major financial stake in choosing the highest value health care
 - Managed care was an agreement between purchasers and health plans
 - The challenge is bringing doctors and patients into the cost-control process
- Market is increasingly concentrated, limiting effective competition
 - Most evident in the small group market, where 2 companies have a 92% market share – both oligopoly and oligopsony issues
 - Increasingly a problem in the hospital market – although effects are less striking in Maryland because of the all-payer system
- Consumers lack good information
 - To compare the costs, quality, and benefits of health plans
 - To compare the costs and quality of providers
 - To evaluate alternative treatments for effectiveness and value

Fundamental Issues (cont.)

■ Risk pools - fundamental but full of complex issues

- Types of pools
 - Employment
 - Association membership
 - Geography (state-wide pool)
 - Group / individual markets
 - Low income
 - High risk pools
- Maintaining the integrity of the pool – avoiding death spiral
 - Representative array of risks
 - Protect boundaries – avoid adverse selection
- Rating principles
 - Community, blended, or full risk rating
 - Are the rules for new entrants the same as established members
- Benefit design
 - Role of state mandates or minimum benefit rules for the pool
- Choice of plans within the pool
 - Highly desirable option for individuals
 - Adverse selection among plans must be addressed

Fundamental Issues (cont.)

■ Access to health insurance and health care

- In 2003, approximately 740,000 Marylanders were uninsured (13.6%)
 - When corrected for the undercount of Medicaid enrollees and for those Medicaid eligible but not enrolled, the number is approximately 500,000
- Key facts about the uninsured:
 - The majority are young and healthy
 - 87% live in families with at least one adult worker
 - 61% are adults with no children
 - 49% have family incomes below 200% of the Federal Poverty Level, but
 - 34% have family incomes above 300% FPL
 - 29% are not US citizens
 - 48% of Maryland's Hispanic population and 17% of its African-American population are uninsured
- Being uninsured reduces access to health care and contributes to poor health
- Care is often provided in the most expensive setting with the least continuity of care – the Emergency Department
- We all pay the cost of caring for Marylanders who either cannot afford or choose not to get health insurance

■ The Costs of the Uninsured in Maryland *

– Direct costs – estimated at \$1.8 billion

■ Maryland State government

- increased hospital rates \$ 34 million
- state public and mental health programs \$439 million

■ Federal government

- increased hospital rates \$239 million
- share of public/mental health programs and FQHCs \$195 million

■ Local governments

\$ 14 million

■ Health plans – increased hospital rates

\$165 million

■ Private physicians – uncompensated care

\$295 million

■ Out of pocket payments by the uninsured

\$445 million

– Indirect costs - estimated at \$1.4-\$2.9 billion

■ poorer health, less productivity

■ Premiums for family coverage were estimated to be \$948 higher because of uncompensated care in 2005

* Source: “Maryland HRSA State Planning Grant: The Costs of Not Having Health Insurance in the State of Maryland” – 2002 estimates projected to 2007

II.

Quality, Outcomes, and Value Initiatives

Quality, Outcomes, and Value Initiatives

- Expanded health plan evaluations
 - Collaboration with Mid-Atlantic and National Business Groups on Health to broaden performance measures
- Expanded hospital quality measures
 - Infections
 - Cardiac care
- Expanded nursing home quality measures
 - Administration of influenza vaccination during the flu season
 - Administration of pneumococcal vaccine
 - Experience of care surveys
- Develop quality measures for assisted living, home care, community-based service
 - Collaborative with AHRQ/CMS
- Price transparency
 - Payments to hospitals for common DRGs
 - Includes both health plan payments and patient out of pocket
 - Payments to providers for ambulatory care services
 - By specialty and region
 - Includes both health plan payments and patient out of pocket

III.

**Broad initiatives to promote higher value in
health care expenditures**

Strategies to Address Rising Health Care Costs

- **Consumer incentives** to choose healthy life style and high value health care
 - Premium reduction for non-smokers, normal weight
 - Health Savings Accounts (HSAs), Healthcare Reimbursement Arrangements (HRAs), and Health Opportunity Accounts (HOAs)
 - Tiered coinsurance based on evidence of effectiveness and cost-effectiveness
 - Incentives for participation in disease management programs, when indicated
 - High performance networks, centers of excellence
- **Provider incentives** to deliver high value, high quality care
 - Pay for value / pay for performance
 - High performance networks
 - Pay for use of health IT, especially decision support software
 - Medical liability protection for guideline-concordant care, other medical liability reforms
 - Confidential or public reporting of detailed performance measures

IV.

Health Information Technology Initiatives

Health Information Technology Initiatives

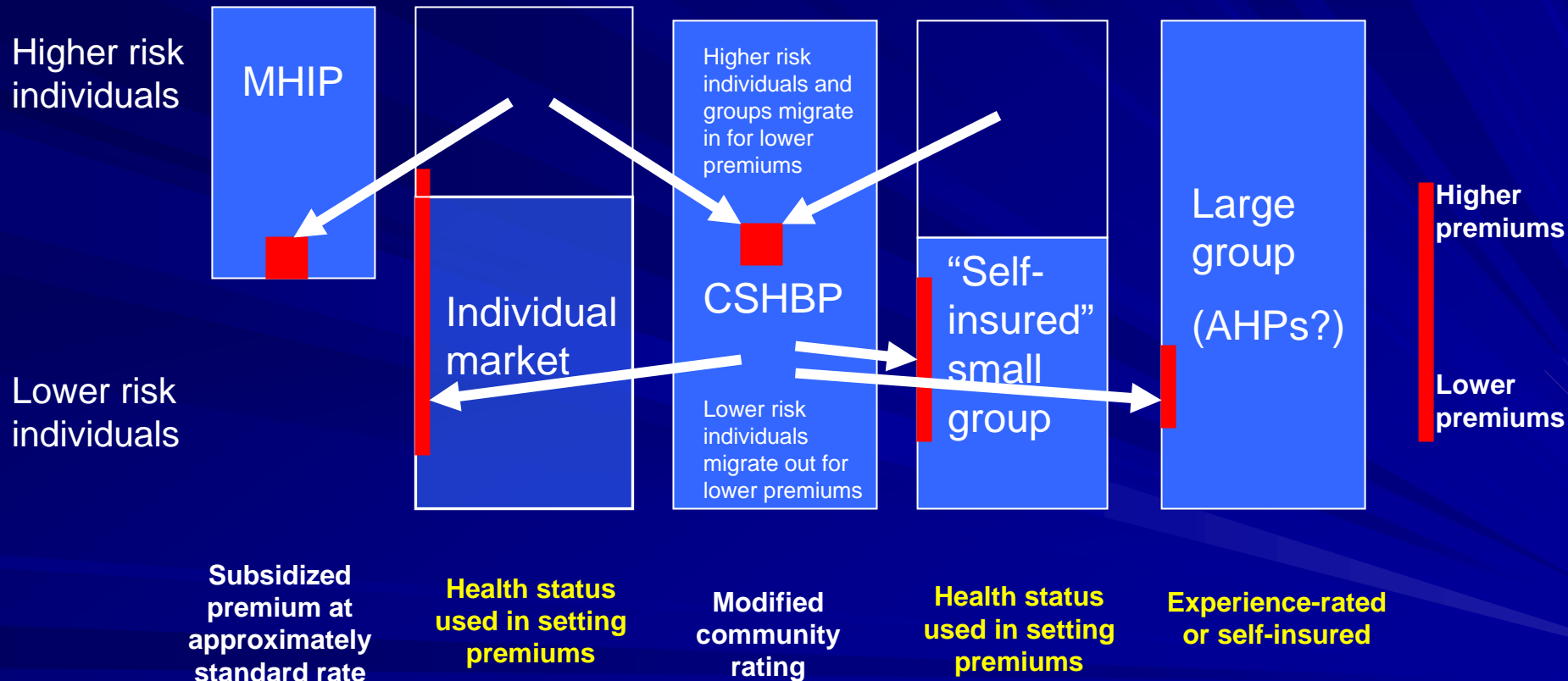
- **Deliver the right information** about the patient, treatment options, and coverage to the point of care to:
 - Improve quality
 - Prevent medical errors
 - Promote value
- **Gathering the right information** to:
 - Determine what works
 - Identify adverse effects
 - Conduct biosurveillance
- **Two key components:**
 - **Electronic health records** with decision support
 - Private and secure **information exchange**
- **State efforts**
 - Task Force on the Electronic Health Record
 - Privacy and Security Study
 - Competitive planning projects for health information exchange with HSCRC (2007)
 - Implementation project for health information exchange with HSCRC (2008)

V.

Specific Small Group Market Options

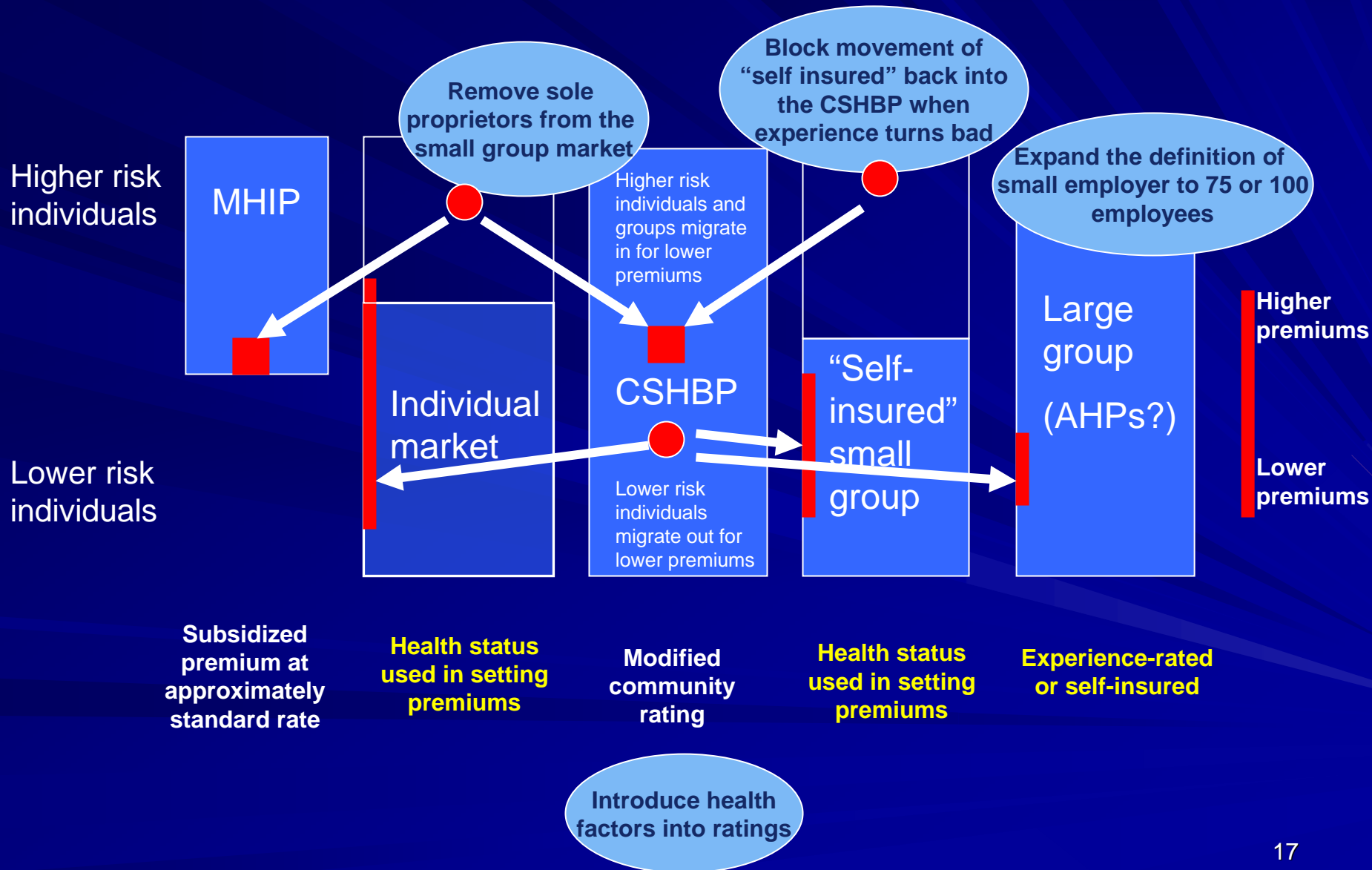
Health, Risk, and the Marketplace

Risk selection harms the pool when rating principles differ



Health, Risk, and the Marketplace

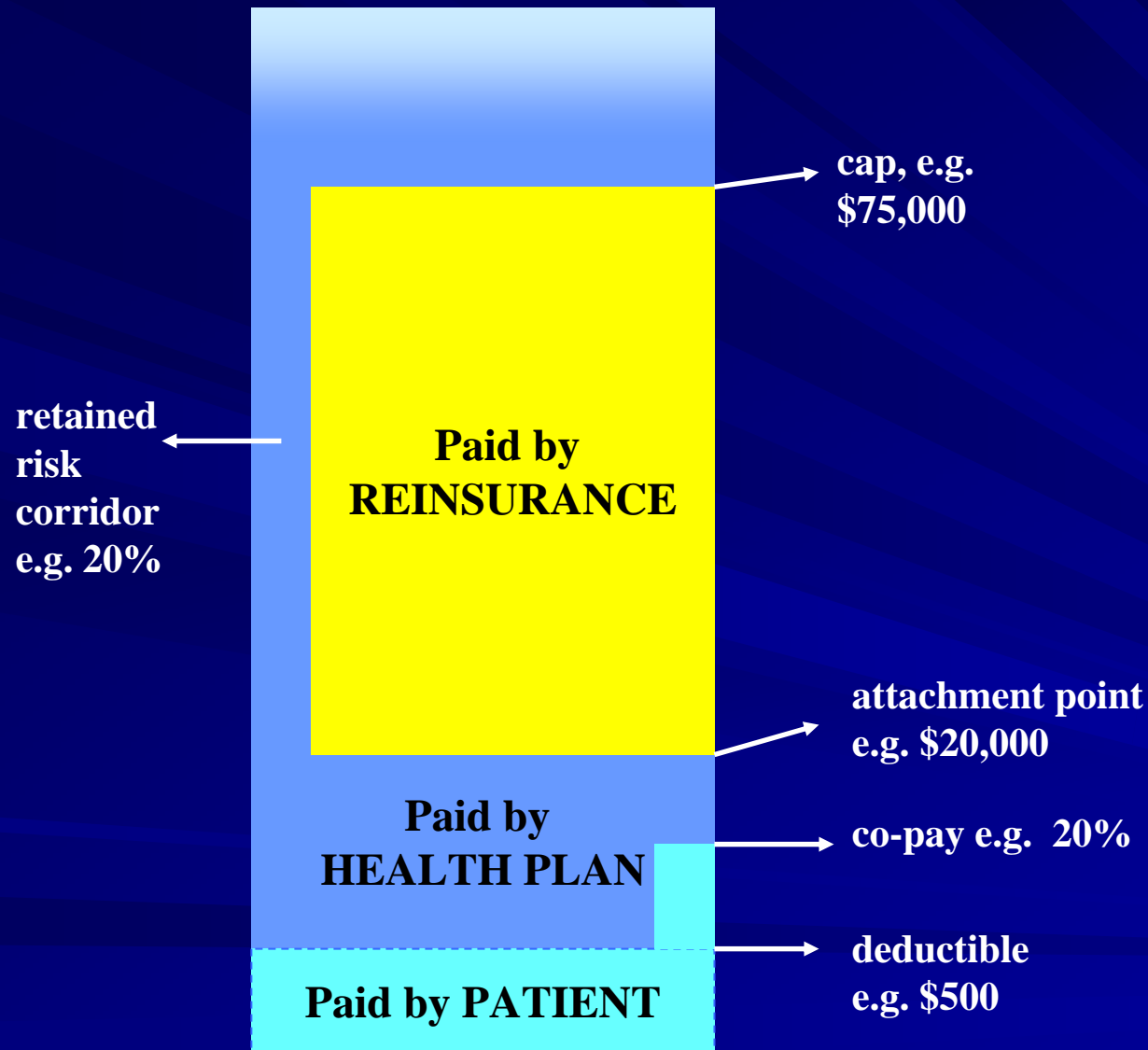
Risk selection harms the pool when rating principles differ



Specific Small Group Market Options

- NAIC 1993 rating standards
- Strategies to address risk selection from ERISA plans or uninsured
 - Rate on entry to pool
 - Institute time-limited pre-existing condition exclusions
- Expansion to 75 or 100 employee groups
- Internet-based intermediary proposal
- Subsidized reinsurance for the SGM

The Concept of Reinsurance



Reinsurance can be used to:

- Reduce premiums through government subsidy
- Compensate for adverse risk selection among plans

VI.

Broader health reform principles and options

States as the Laboratories of Federalism

- States vary greatly in:
 - Current employer sponsored coverage
 - Current Medicaid coverage
 - Workforce and economic conditions
 - Those variations affect the feasibility of reform
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- Compare three states exploring comprehensive reform: Maryland, Massachusetts, California

Insurance and Poverty Status

Non-elderly in 2004	MD	MA	CA	U.S.
Percent Uninsured	16.3%	13.1%	20.7%	17.8%
Percent with ESI	69.2%	69.4	55.6%	63.2%
Percent on Medicaid	8.1%	14.5%	16.8%	13.3%
<i>Medicaid Eligibility Levels</i>				
<i>Parents</i>	<i>39%</i>	<i>133%</i>	<i>107%</i>	
<i>Pregnant Women</i>	<i>250%</i>	<i>200%</i>	<i>200%</i>	
<i>Children (<19)</i>	<i>200%</i>	<i>150%</i>	<i>(1-5) 133%</i> <i>(5-19) 100%</i>	
<i>SCHIP (children <19)</i>	<i>300%</i>	<i>200%*</i>	<i>250%</i>	
Percent Under 250% FPL	29.5%	28.7%	42.8%	38.8%
Percent Under 250% Who Are Uninsured	32.5%	22.4%	31.6%	29.3%
Percent Who Are Uninsured & Under 250% FPL	9.6%	6.4%	13.5%	11.4%

Source: U.S Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2005.

* Massachusetts' recently enacted health care reforms expand MassHealth eligibility for children from 200% to 300% FPL

Workforce & Economic Characteristics

	MD	MA	CA	U.S.
Percent of Private Sector Firms < 50 Employees (2004)	26.9%	27.4%	29.8%	29.1%
Avg. Employee-only Premium in Private Sector Firms < 50 Employees (2004)	\$3,838	\$4,509	\$3,372	\$3,764
Percent of Workers in Firms with Majority of Low Wage Workers (< \$10/hr.) (2004)	22.3%	19.1%	26.1%	30.0%
Per Capita Income (2005)	\$31,109	\$31,007	\$26,800	\$25,035
Unemployment Rate (2005)	4.1	4.8	5.4	5.1

Sources: Tabulations based on data from 2004 MEPS Survey, U.S. Agency for Healthcare Research and Quality; Data Profile Highlights - 2005 American Community Survey, U.S. Census Bureau; and Bureau of Labor Statistics, U.S. Department of Labor, www.bls.gov/lau/lastrk05.htm

Key Considerations

■ How do the reform options address the following:

- The Exchange
 - Governance
 - What markets are included (non-group/small group)
 - Basic rating principles
 - Role of brokers, TPAs, and internet resources
- Individual responsibility and individual choice
- Employer responsibilities
- Additional protections for the risk pool (new entrants)
- Benefit designs, covered services, and mandates
- Compensating health plans for adverse selection
 - Reinsurance and risk adjustment of premiums
- Subsidizing coverage for low-income individuals and families
- Funding of coverage expansions

Massachusetts' Health Care Reform Bill

- Impetus – Threat of losing \$385 million in federal funds
- Signed into law by Gov. Romney in April 2006
- Aims to Cover 95% of Uninsured within 3 years through the following components:
 - **Individual Responsibility**
 - All residents must obtain coverage
 - Penalties assessed if “affordable” coverage is available
 - **Employer Responsibility**
 - “Fair Share” employer contribution – Employers with 11+ workers who don’t offer coverage must pay \$295 per worker
 - Employers must facilitate Section 125 “cafeteria plan” for pre-tax health insurance
 - “Free Rider Surcharge” – Non-offering employers (11+ workers) with frequent Uncompensated Care Pool users may be charged up to 100% of costs over \$50K

MA Health Care Reform (cont.)

– Insurance Market Reforms

- Creates Commonwealth Health Insurance Connector (Administered by quasi-public authority)
 - Makes private plans available on pre-tax basis
 - Reduces administrative burden for small businesses
 - Allows portability when changing jobs
 - Allows part-time workers to combine employer contributions
- Merge non-group (individual) market with small group market
- Modified community rating –
 - Rating factors: age, industry, geographic area, wellness program usage, tobacco usage, or rate basis type
- Extends definition of dependent coverage

– MassHealth/Medicaid Expansion

- Children's coverage expands from 300% FPL (\$60,000/family of 4) from 200% FPL

– State-sponsored Incentives

- Commonwealth Care Health Insurance Program
 - Subsidized coverage for lower income uninsured below 300% FPL (no deductibles; no premium if below poverty; sliding scale between 100-300% FPL)

Senator Pipkin's "CHOICE" Plan

– Individual Responsibility

- None

– Employer Responsibility

- None

– Insurance Market Reforms

- Creates Maryland Health Insurance Exchange (Governed by MHCC)
- Merges individual and small group markets
- Eliminates MHIP over 3 years
- Gives large employers the option to participate
- Mandates that Maryland state employees participate
- Provides guaranteed issue, renewal and portability among plans
- Eliminates mandates

– Rating Principles

- Modified community rating, adjusted for age (not to exceed +/-55% of the community rate) and geography (up to 20%)

Senator Pipkin's "CHOICE" Plan (cont.)

- **Enrollment/Claims Processing**
 - Brokers are entry point into Exchange
 - Broker commissions of not less than 5% of premium
 - MHCC can contract with TPAs
- **Reinsurance/Risk Transfer**
 - Creates a Health Insurance Risk Transfer Pool
- **State Sponsored Incentives**
 - Tax credits against state income tax, not to exceed the tax amount
- **Medicaid Expansion**
 - None
- **Eliminates CON and sunsets HSCRC**

MARYLAND HEALTH

A Five Year Plan to:

- Create Maryland Health, a private-public insurance exchange
- Emphasize personal responsibility for health and health care coverage
- Make insurance affordable for low income Marylanders through premium support
- Promote competition and innovation in the health insurance market
- Promote consumer-directed health care and evidence-based medicine

Guiding Principles of Maryland Health

- **The goal:** access to health insurance and high quality health care for all Marylanders
- **Individuals take personal responsibility** for insurance coverage, rather than be free riders
- **Individuals choose** their health plan – and should be able to keep the same coverage when changing jobs within Maryland
 - Employee's premium may change
- **Government helps low-income individuals purchase health insurance** through premium support
- **Incentives** encourage doctors and patients to choose based on value
- **Better information is essential** to better choices
- Use of the internet for information dissemination, education, and comparative analysis to help with consumer choice
- There's no magical answer – affordable health care will require thoughtful choices and difficult compromises

Enhancing Personal Responsibility

- Maryland Health would create a **state-wide program to spread risk and offer choice** in the same way a large employer's health plan spreads risk and offers choice
- **Broad participation** by all eligible Marylanders is essential to success of the risk pool
- Individuals who do not purchase insurance increase both the taxes and the cost of health insurance for everyone else
- Health insurance coverage, like automobile insurance, should be expected of everyone
- **Enhancing personal responsibility requires:**
 - Affordable insurance plans
 - Premium support for low income individuals
 - Incentives and penalties to assure that everyone is “in the pool” and contributing premiums

Employer Responsibility

- Establish a **Section 125 plan** (cafeteria plan) for their employees
 - Deduct employee contributions to premium from wages/salary
 - Employees save both income tax and FICA tax
 - Employers save FICA taxes

- **Identify the level of contribution** they would make toward premiums and/or health savings accounts
 - Employees working more than 17.5 hours a week would be entitled to a proportionate share of any contributions made to full-time employees
 - Although not required to contribute toward health benefits, all employers would be encouraged to do so

Maryland Health: A Public-Private Insurance Exchange

Crucial unresolved design issue: A single insurance exchange serving both the individual market and the small group market

■ Maryland Health, like other proposed exchanges:

- Gives employees and individuals **greater choice** among health plans
- Structures the market, providing:
 - Better competition among health plans
 - Better comparative information to guide individual choice
 - Greater flexibility and innovation in plan designs
- Provides **portability** between jobs, continuity of care, ability to combine health benefits from several part time (or full time) jobs
- Makes it **simpler for employers** to provide health insurance
 - Administrative burdens significantly reduced
 - Employer chooses a defined contribution
 - Provides a way for employers who don't currently offer health benefits to contribute toward health insurance costs

■ Maryland Health (cont.)

- Efficiently combines individual and employer contributions with:
 - A premium support program for low-income Marylanders
 - Any available Federal tax credits for low-income individuals
- Facilitates the establishment of employers' Section 125 plans that exclude employee premium contributions from income
- Can manage risk selection among plans by:
 - Assessing whether there is risk selection
 - Adjusting premiums paid to plans based on the risks they enroll, or
 - Administering a plan of reinsurance, or
 - Assuring that high cost individuals receive effective disease or case management

Maryland Health (cont.)

■ Governance

- A non-governmental, non-profit entity with broad stakeholder representation
- Brokers are the entry point for information, education and ongoing support services
- The administrative functions (including broker support, risk assessment of new entrants, billing) would be contracted to Third Party Administrators (TPAs)

■ Rating principles and protection of risk pool

- **Modified community rating**
- To ensure the integrity of the risk pool, **new entrants pay premiums that reflect health on entry**
- These premiums for new entrants **transition to modified community rating over 5 years**

Unresolved Issues

■ Operation of Maryland Health

- How premiums would be quoted and presented
- What information employers would have to choose their contributions level
- How health status will be assessed
- How the health status of new entrants would affect premiums

■ Benefit designs

- What is an acceptable benefit design for the “affordability” test
- What incentives to individuals for healthy behaviors, disease management will be allowed / encouraged

■ Premium support

- What level of premium support will be offered at different income levels
- How is affordability defined
- What will it cost
- What funding sources could be shifted to premium support

Analyses Underway

- Insuring the uninsured (John Sheils, The Lewin Group)
 - Uninsured by employment status, adjusted for the Medicaid undercount
 - Design and cost of various premium support options
 - Design of incentives to participate and penalties for non-participation
 - Estimates of employer response to premium subsidies
 - Offers from employers previously offering no health benefits
 - Employer erosion due to presence of a subsidy
 - Effect of non-discrimination rules
- Financing the premium subsidy (Mike O'Grady, NORC)
 - Potential redistribution of state and federal funding
- Benefit design (John Welch, Mercer)
 - Options to produce more affordable yet still acceptable benefit designs